

PROVIDER TIERING NOTICE

Date: _____

Sponsor Name: _____

Provider Name: _____

Address: _____

Address: _____

You have been determined to receive Tier ____ rates beginning ____/____/____ for your meals according to:

School:

_____ Free & Reduced School sheet from report

_____ School Name _____ %
(Must be 50% or more to qualify)
_____/_____/____ Expiration Date (Must redetermine every 5 years)

By Census:

Source: _____

Expiration Date ____/____/____

By Income: (Must redetermine each year)

_____ Income Application _____/_____/____ Expiration Date
Number of own children claimed _____
Number of related over capacity claimed _____